THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from 3-MMC

3-Methylmethcathinone (metaphedrone) and the polydrug patterns around it. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE.** 3-MMC's defining danger is speed: effects fade within about an hour, which drives compulsive redosing, and the cumulative cardiovascular strain across a binge, not any single dose, is what most often turns dangerous.
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> **Go to an emergency department or call 911 for:** chest pain, a racing or irregular heartbeat, a dangerously high body temperature, seizure, severe agitation or paranoia that is escalating, or loss of consciousness. If opioids were also used and there is slow or stopped breathing, blue lips or fingertips, or unresponsiveness: give naloxone and call 911. Tell paramedics everything that was used. If you also dose GHB several times a day, do not stop the GHB abruptly.
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Never Use Alone: 1-800-484-3731

1. Before you start

This is a route through the Recovery Kernel for people recovering from 3-MMC, including people who use it in chemsex settings or alongside other substances, and for the people supporting them. The Kernel's two 3-MMC chapters deliberately give no dosing thresholds, redosing intervals, or administration guidance, because the danger is cumulative and session-based and any number would misrepresent an unpredictable risk as a manageable one. This guide does the same. Five rules set the order of everything that follows.

- **The danger is the binge and the mix, not the withdrawal.** 3-MMC withdrawal on its own is rarely the most dangerous part. Combination toxicity is the leading pattern in 3-MMC-related deaths, most often with opioids and other stimulants.
- **Plan how a binge ends before you need to.** There is rarely a single "last dose." The hardest hour is the one right after the last dose, when everything says "one more." The highest-leverage skill is deciding in advance who you tell, what you remove from reach, and what you do in that hour (Supplemental Ch. 33 §1).
- **Get your heart checked first.** A cardiovascular assessment is a reasonable starting point even before addressing the pattern itself, especially if you had palpitations, chest discomfort, or a very high heart rate during binges.
- **Treat the whole pattern, not 3-MMC in isolation.** If GHB, methamphetamine, opioids, or injection are part of it, each carries its own safety profile, and treating 3-MMC alone usually underestimates how long stabilization takes (Supp. Ch. 33 §3).
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The two core chapters are Chapter 15 (How to Recover from 3-MMC) and Chapter 33 (Discontinuance Protocol: 3-MMC and Polypharmacy). Chapter 11 (Methamphetamine and Amphetamine-Class Stimulants) is the "core stimulant guide" that Chapter 15 builds on. Chapter 29 covers chemsex. Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapters 15, 29, and 33 cite Compendium protocols by number, and some numbers do not match the Compendium as printed. They call Protocol 09 "Sleep Architecture" (printed: The Gut-Brain Axis; sleep is Protocol 17), Protocol 05 "Environmental Redesign" (printed: Digital Detox), Protocol 01 "Shelter & Stabilization" (printed: Emergency Triage), and Protocol 28 "Natural Addiction Porting" (printed: The Vigilant Mind; the porting paper is C-28, The Recast). Chapter 29's "Protocol 42" for HIV prevention is printed as Deploying Anti-Viral Firewalls, but the Compendium also prints a different Protocol 42, The Experimental Branch. The "Protocol 35S series" for chemsex is not in the provided text: use Supp. Ch. 29 instead. This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For 3-MMC, watch for redosing every 20 to 40 minutes to chase a fading effect — the short duration makes this the guide's most repeated warning.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as "the plan must be wrong," answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 8 applies only if chemsex or other substances are part of your pattern. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: emergency signs, opioids in the mix, GHB dependence, heart and psychiatric history.	Supp. Ch. 15 opening Supp. Ch. 33 §§0, 6.4, 7 Main Book, Quick-Start Step 1
1	Days 0–7	Medical check. Plan how the binge ends. Get through the first hours after the last dose.	Supp. Ch. 33 §§1–3, 8 Supp. Ch. 15 §3 Supp. Ch. 32, 31, 35 if co-use
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3

Step	When	What you do	Turn to
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 15 §2 Compendium P06
4	Weeks 2–6	Resolve your combined profile. Carry a prescriber card.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 15 §2
5	Day 1 to Month 6	Build the biological foundation with your physician.	Supp. Ch. 15 §§4–5 Supp. Ch. 33 §9 Supp. Ch. 11 §4; Compendium P07, P17, P18
6	Weeks 1–12, then ongoing	Remove access. Learn the fast craving interrupt. Handle apps, venues, and weekends.	Supp. Ch. 15 §4.4 Supp. Ch. 33 §§1, 9 Compendium P05, P20, P21, P08, P33
7	Months 1–24	Build a repeatable reward with fast feedback.	Supp. Ch. 15 §6 Supp. Ch. 11 §6, Ch. 36, Ch. 3 Compendium P19, P03, P29
8	If chemsex or polydrug	Coordinate tracks. Sexual health first. Sober community.	Supp. Ch. 29 Supp. Ch. 33 §6 Compendium P42 (Anti-Viral Firewalls)
9	Months 2–12+	Identity, inventory, work, family.	Supp. Ch. 42, 43, 51 Compendium C-28, P23, P24, P22
10	Year 1 to Year 10	Steward: review, transplant, mentor.	Supp. Ch. 44, 6, 38 Compendium P02, P13 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Know the emergency signs above, and know that they become more likely the longer a binge continues, because each redose adds to cumulative strain instead of starting from zero. If opioids are part of the pattern, including opioids used to come down, the Kernel calls that the highest-priority risk in its 3-MMC material: a stimulant can hide the sedation of an opioid overdose until it is advanced. Carry naloxone and never use alone. If you dose GHB several times a day, that has its own withdrawal emergency and needs medical supervision; read the GHB material before you stop anything.

The Kernel sorts use into four levels. Level 1 (one or two isolated uses) and Level 2 (occasional, limited redosing) usually need only the biological-reconstruction sections and a physician check-in if any cardiovascular symptoms occurred. Level 3 (recurring multi-redose sessions) means physician involvement, particularly a cardiovascular check. Level 4 (frequent binges, chemsex, or polydrug, often with GHB, methamphetamine, opioids, or injection) means medical supervision and addressing the full substance pattern. A personal or family history of heart conditions, high blood pressure, psychosis, or bipolar disorder changes the risk substantially, so disclose it to any physician involved.

Turn to: Supp. Ch. 15, opening emergency box. Supp. Ch. 33 §0 (immediate safety), §6.4 (pre-existing conditions), §7 (use-pattern levels), §10 (emergency recognition). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Medical check and ending the binge (Days 0–7)

The crash arrives fast, closer to a sharp drop than a gradual fade: sharp fatigue, low mood, and often an intense residual pull to redose. That window is the highest-risk moment for the binge continuing rather than ending. Days 1 to 5 bring irritability, anxiety, disrupted sleep, and appetite changes. Palpitations or a high resting heart rate can outlast the drug by a day or two after a heavy binge and warrant medical attention if they do not settle. There is no FDA-approved medication for 3-MMC or synthetic cathinone withdrawal and no standardized detox protocol, so the care you can ask for is a cardiovascular assessment, medical monitoring, and support.

Removing or restricting access to supply is unusually high-leverage because availability directly drives the redosing loop. Decide in advance who you will tell and what leaves your reach. For your appointment, bring an honest account of typical session length, redosing frequency, and route; every co-used substance, especially opioids, other stimulants, GHB, and alcohol; any cardiovascular symptoms during or after binges, even ones that resolved; and whether injection has been part of the pattern, so bloodborne virus testing can be arranged. If you have injected, plan for HIV and hepatitis C testing and injection-site assessment. Harm reduction services with sterile equipment and chemsex-specific support exist in most major cities and many operate anonymously.

Turn to: Supp. Ch. 33 §1 (why this is organized around the binge), §2 (withdrawal timeline), §3 (how long until things feel normal), §6.3 (injection use), §8 (medical protocol; what to bring). Supp. Ch. 15 §3 (detox and the timeline). If methamphetamine is also involved: Supp. Ch. 32. GHB: Supp. Ch. 31, Section 0. Opioids: Supp. Ch. 35, Section 0.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are physically stable. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; the Warrior profile is the one the Kernel links most to 3-MMC), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Ch. 7 (Harm Reduction), only if you are still using → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 7 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no 3-MMC case study, but Case 05 (methamphetamine) and Case 15 (polydrug) are the nearest profiles and set your expectations. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

For 3-MMC, the Kernel names five genes: **DRD2** (Taq1A), **COMT** (Val158Met), **MAOA** (uVNTR and rs6323), **SLC6A4** (5-HTTLPR), and **MTHFR**. If chemsex is part of your pattern, add GABRA2 (which governs GHB dependence and withdrawal severity and is essential for a medical team), DAT1/SLC6A3 (linked to ADHD, and meth self-medication is a documented pathway), and CYP2B6 (GHB metabolism). Until results arrive, ask yourself: did you find yourself redosing every 30 to 60 minutes almost automatically, more than with other stimulants; did sessions run far past the planned end; do you struggle with depression, blunting, or fatigue even when clean? The Kernel reads these as the short half-life interacting with a DRD2 deficit or Warrior COMT, the redosing loop rather than willpower, and probable MTHFR involvement.

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 15 §2 (DNA panel for 3-MMC recovery; reading your profile before you have results). Supp. Ch. 29 §2 (chemsex panel). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your combined profile (Weeks 2–6)

The Kernel's frame: 3-MMC's very short duration means the biological "want more" signal fires faster and more often than with almost any other cathinone. That is a pharmacokinetic fact about the molecule, not a character flaw. Your genes shaped how strongly the redosing loop took hold. Write your profile down and carry key results on a card.

If your result is...	What changes	Source
DRD2 A1 (fewer D2 receptors)	The short window before the effect fades may intensify the drive to redose. Build several parallel reward sources, never one all-consuming pursuit.	Supp. Ch. 15 §2; Ch. 5 System 5
COMT Val/Val (Warrior)	The fast, repeatable hit is especially compelling. Recovery needs genuine intensity with fast feedback, not only calm.	Supp. Ch. 15 §2, §6; Main Book Ch. 3
MAOA (faster clearance)	Faster baseline monoamine breakdown may shorten the high and sharpen the crash, reinforcing the cycle.	Supp. Ch. 15 §2; Ch. 33 §5
SLC6A4 short/short	Shapes the entactogenic, socially warm component. Support serotonin alongside dopamine.	Supp. Ch. 15 §2; Ch. 29 §2
MTHFR variants	Methylation support is foundational for rebuilding dopamine, serotonin, and norepinephrine supply. Avoid synthetic folic acid with any T variant.	Supp. Ch. 15 §4.1; Main Book Ch. 2
GABRA2 high-risk (if GHB used)	Slower GHB taper, more severe PAWS, higher seizure risk. Tell the medical team.	Supp. Ch. 29 §2; Ch. 31 §5
DAT1 / SLC6A3 10-repeat	Stronger response to stimulant transporter blockade and linked to ADHD. Ask about an ADHD evaluation.	Supp. Ch. 29 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 15 §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the biological foundation (Day 1 to Month 6)

Begin as soon as you can tolerate it. The Kernel's 3-MMC foundation has three parts: methylation support (5-MTHF is the folate form your brain can use directly regardless of MTHFR status), then dopamine precursor support and receptor rehabilitation once you are eating regularly and the acute phase is stabilizing, typically several days at minimum, and sleep repair. Post-binge basics matter too: magnesium, omega-3, and hydration with electrolytes, since binges frequently involve dehydration. D2 receptor upregulation happens automatically with abstinence, and the goal is to support and accelerate it. Because a 3-MMC binge can involve many redosing cycles, receptor exposure across a heavy-use period can be unusually high relative to total drug consumed, which is worth remembering when you set expectations.

There is no FDA-approved medication for synthetic cathinone use disorder. Bupropion and N-acetylcysteine, used off-label for stimulant use disorder more broadly, may be discussed with a physician, and whether they fit depends on your full history, including any cardiovascular symptoms during binges. Those symptoms deserve their own evaluation. The dose tables for the stimulant framework are in Supp. Ch. 11 §4. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

Turn to: Supp. Ch. 15 §4 (4.1 methylation, 4.2 dopamine precursors, 4.3 receptor rehabilitation), §5 (rebuilding sleep), §8 (the medical support layer). Supp. Ch. 33 §9 (Tiers 1–3). Supp. Ch. 11 §4 (dopamine reconstruction) and §8. Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), Protocol 07 (Neuroplasticity), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — Cravings, access, and the redosing loop (Weeks 1–12, then ongoing)

3-MMC cravings can convert to redosing within minutes during active use and stay sharp in the hours after stopping, so the interrupt is built for speed: locate it in the body and name where it sits, since this is a body event, not a command; do something immediately physical and demanding (a fast walk, cold water on the face, push-ups) within the first sixty seconds; move away from the supply and the use environment, the single most important variable for a short-window craving; make contact with one person, because isolation is where a redosing decision happens fastest; then breathe (4-7-8, four to eight cycles); then document it.

Redesign the settings where binges happened, with concrete changes rather than intentions: chemsex apps, specific venues, specific contacts. If chemsex is part of your pattern, the Kernel says the apps must come down within the first 24 hours and stay down for at least 90 days, and that the session times are compound cues: the craving can appear at those times of the week months into recovery, so plan them. Loneliness, sexual arousal, and stress are also triggers.

Turn to: Supp. Ch. 15 §4.4 (craving interrupt). Supp. Ch. 33 §1 and §9, Tier 3 (access and settings). Supp. Ch. 29 §7 (chemsex craving triggers and the 5-minute interrupt). Compendium Protocol 05 (Digital Detox), Protocol 20 (Mapping the Terrain), Protocol 21 (Reading the Collapse), Protocol 08 (Social Environment), Protocol 33 (The Boundary Architect).

Step 7 — Build a repeatable reward (Months 1–24)

3-MMC's specific appeal is repeatability: re-triggering the peak again and again inside one session. Start with a function audit. What did it give you: energy, sociability, confidence, an easily repeatable peak, escape from a flat baseline? Every item is a real need that did not disappear with the drug. The Kernel's architecture is one high-intensity physical challenge with frequent, repeatable feedback (competitive sport, intervals, martial arts); a skill with a fast, visible feedback loop, such as music, a craft, or a game with a mastery ladder; and genuine social connection built around shared activity, not just proximity. Not one outlet, but a mastery curve with real, frequent feedback.

Timelines: for sustained binge patterns the central recovery phase typically runs 2 to 6 weeks before mood and sleep feel consistently steady, with intermittent PAWS episodes possible for months (1 to 6). Occasional, lighter use usually resolves in days. If a polydrug pattern is involved, expect longer.

Turn to: Supp. Ch. 15 §6 (porting the addiction: same engine, different address). Supp. Ch. 11 §6. Supp. Ch. 36 (Roots and Reversal). Supp. Ch. 3 (timeline recalibration). Compendium Protocol 19 (The Body in Motion), Protocol 03 (Sonic Architecture), Protocol 29 (The Peacetime Paradox).

Step 8 — If chemsex or other substances are part of it

The Kernel says chemsex is not three addictions but one addiction expressed through several mechanisms, organized around a context (sexual experience) and a community, with health consequences that go beyond neurobiology. Each substance needs its own recovery track, run in parallel and coordinated, with the medically dangerous one addressed first (GHB, when dosed regularly). The sexual health assessment belongs in the first week: HIV testing, PEP within 72 hours of a possible exposure, PrEP before any further sexual activity if you are negative, STI testing at least every three months during the first year, hepatitis B vaccination status, and hepatitis C testing if you injected. Expect a "flatline" of desire in early recovery, roughly 1 to 3 months after meth-primary patterns and 3 to 6 or more after frequent MDMA. It is a season, not a verdict, and testing whether desire has returned delays it. Recovery does not require leaving your community or your sexual identity. It requires building a sober version of what the scene provided: belonging, connection, and sexual expression.

Turn to: Supp. Ch. 29 (How to Recover from Chemsex), especially §0 (medical emergencies), §5 (sexual health, the chemical intimacy trap, the flatline), §6 (HIV and health management), §8 (community and identity). Supp. Ch. 33 §6 (polypharmacy: opioids, GHB and methamphetamine, injection). Compendium Protocol 42 (Deploying Anti-Viral Firewalls). Sober community options the Kernel names include Crystal Meth Anonymous, SMART Recovery LGBTQ+ meetings, and chemsex-informed therapists and health services.

Step 9 — Identity and rebuilding a life (Months 2–12+, revisited later)

If your sense of who you are was organized around sessions, sobriety means building an identity that does not require them, not subtracting one. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Trauma-informed work belongs after biological stability. Family, money, and work follow.

Turn to: Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Supp. Ch. 39 (Complex Trauma and the Substance Connection). Compendium Protocol 23 (Rebuilding the Ledger), Protocol 24 (Returning to Work), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral), Protocol 25 (The Open Door). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

Step 10 — The long game (Year 1 to Year 10)

The Kernel maps the first months of 3-MMC recovery in detail and does not project beyond that. Navigation after that shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap, a regular review of whether each medication is still needed). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The sexual health row applies if chemsex was part of your pattern.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Binge-end plan; heart check	Off-label medications reviewed [1]	Heart history stays on file	Naloxone kept; no mixing [7]
Biology and genome	DRD2, COMT, MAOA; methylation base	Retest labs; step stack to upkeep [2]	Prescriber card: COMT, MAOA	Re-check with new meds and age
Access and cues	Supply out of reach; apps, venues, contacts	Apps stay down; cues fainter	Triggers shift: weekends, sex, loneliness [5]	Same plan, rehearsed
Repeatable reward	Fast-feedback challenge daily	Mastery ladder carries the load [3]	Several reward sources	Intensity outlets, still weekly
Sleep and mood	Rebuild sleep; crash, PAWS	Sleep restored; PAWS rare	Mood plan, clinician-led	Stress plan, sleep habits
Sexual health and context	Testing, PrEP; flatline navigation (if chemsex)	Sober sexuality; community built	Routine testing, PrEP or ART	Routine testing, lifelong
Identity and Manning	Function audit: what it gave you	Transplant; return to work [4]	Manning: mentor, peer support [6]	Mentor or run a group

The seven shifts

1. **Year 3, medical follow-up moves from urgent to scheduled.** The Kernel offers no approved medication for cathinone use disorder, only off-label options such as bupropion and NAC to discuss with a physician (Supp. Ch. 15 §8). By year 3, review whether anything is still needed and what marks readiness to stop, using the review standard in Compendium Protocol 13, and keep any cardiovascular follow-up that binge-era symptoms called for.

2. **Year 3, the stack moves from building to upkeep.** Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the repeatable reward carries the load.** The Kernel's replacement for 3-MMC is a mastery curve with real, frequent feedback (Supp. Ch. 15 §6). By year 3 that ladder is ordinary life, not an emergency tool.
4. **Year 3, meaning moves up.** As the repair tracks drop to maintenance, redirect the devotion and daily structure the pattern required into a practice (Supp. Ch. 44) and return to work (Compendium Protocol 24).
5. **Year 5, triggers shift from cues to context.** As acute cue craving fades, what remains is the contexts the Kernel names: session times of the week, sexual arousal, loneliness, and stress (Supp. Ch. 29 §7). Reinstating apps or venues becomes a deliberate decision made away from a craving, not a drift. Keep Protocol 21 ready.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). Where chemsex was involved, the Kernel calls the chemsex-informed therapist the most valuable clinical relationship and describes peer communities such as Crystal Meth Anonymous (Supp. Ch. 29 §8), so mentoring and peer support have real value here.
7. **Year 10, no mixing and never using alone.** Combination toxicity is the leading pattern in 3-MMC deaths, most often with opioids and other stimulants (Supp. Ch. 15 opening; Ch. 33 §6.1). Carrying naloxone and never using alone are permanent, alongside the Kernel's GHB rule against combining it with alcohol or other depressants.

What is sourced and what is extrapolated. *Shifts 3 and 7 rest directly on Kernel text. Shifts 1, 2, and 6 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 5 are extrapolations, with 5 partly sourced. The Kernel's detailed 3-MMC timeline ends at PAWS, months 1 to 6, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years for heavy long-term use. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with triage and a heart check first, a planned end to each binge, the biological foundation, access and cues redesigned, a repeatable reward built, the wider pattern coordinated, and then identity and purpose work, this is the outcome the Kernel projects:

- **You get through the hardest hour and the crash.** The acute phase is shorter than with longer-acting stimulants, provided the binge itself has ended. Cardiovascular symptoms are checked rather than assumed to pass.
- **For sustained binge patterns, the central recovery phase runs 2 to 6 weeks,** after which mood and sleep feel consistently steady. Intermittent PAWS, mostly cue-triggered low mood and craving, can continue for months (1 to 6).

- **If chemsex or polydrug use was part of it, expect longer.** The Kernel's own chemsex timelines run from roughly 3 to 12 months for dopamine and serotonin baselines to recover, with meth-related dopamine repair up to 12 to 24 months.
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk or that a return to use cannot happen. It states plainly that the danger of 3-MMC lies in the binge and in combinations, and that treating it in isolation underestimates the timeline.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Acute crash and heart check	Hours to Day 5	The binge ends. Sharp crash, then irritability, anxiety, disrupted sleep. Palpitations that persist are medically assessed.	Supp. Ch. 33 §2; Ch. 15 §3	Clinical timeline
Stabilization	Weeks 1–4	Sleep and appetite gradually normalize. Mood remains fragile.	Supp. Ch. 33 §2	Kernel projection
Central recovery phase	2–6 weeks (sustained binge patterns)	Mood and sleep consistently steady. For occasional lighter use, most acute symptoms resolve within days.	Supp. Ch. 33 §3	Kernel projection
PAWS	Months 1–6	Intermittent low mood and craving, often triggered by cues tied to binge sessions or the people and places around them.	Supp. Ch. 15 §3; Ch. 33 §2	Kernel projection
If chemsex: flatline resolves	About 1–3 months (meth-primary); 3–6+ (frequent MDMA)	Desire returns as dopamine and serotonin systems recover. Do not test or force.	Supp. Ch. 29 §5.3	Kernel projection
If chemsex: neurochemical recovery	Months 3–12; meth dopamine up to 12–24 months	Serotonin baseline recovered; dopamine at or near baseline; GHB track complete with appropriate taper.	Supp. Ch. 29 §§1, 3	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Purpose and service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: nearest analogs only

The Kernel has no 3-MMC case study and gives no 3-MMC-specific projections. The two nearest profiles in Supplemental Chapter 2 are Case 05, a 26-year-old with untreated ADHD using methamphetamine (MTHFR T/T plus COMT Val/Val), and Case 15, a 41-year-old with a polydrug history and reward deficiency (DRD2 A1, MTHFR T/T, COMT Val/Val). Treat these as analogs for a Warrior-profile stimulant pattern, not as predictions for 3-MMC.

Case	Measure	Kernel protocol	Standard treatment
Case 05	12-month abstinence with full biological support and ADHD treatment	62%	15%
Case 05	Functional improvement (work and relationships) at Month 6	73%	25%
Case 05	Craving reduction of 50% or more at Month 3 with the full dopamine stack	67%	10%
Case 15	12-month multi-substance cessation with full protocol	55%	8%
Case 15	Significant anhedonia improvement at Month 6	68%	12%
Case 15	Functional daily living and employment at Month 12	62%	20%
Case 15	No ER or crisis events at 12 months	70%	40%

How to read these numbers. *The Kernel describes them as archetype projections, "probability estimates" for an adherent, biologically confirmed 12-month protocol, drawn from cited studies and NIDA and SAMHSA baselines. They are not guarantees, and the Main Book states that it is not reporting a randomized controlled trial of the Kernel itself. Case 15 also carries the Kernel's own caution that 18 months to full stability is not unusual.*

What changes the outcome

- **Mixing.** Opioids taken with a stimulant mask each other's warning signs. Combination toxicity is the leading pattern in 3-MMC deaths.
- **A binge with no planned end.** Cumulative strain across redoses, not any single dose, is what turns dangerous.
- **Supply within reach.** Availability directly drives the redosing loop.
- **Apps, venues, and contacts left in place.** These are compound cues, and session times of the week keep triggering craving for months.
- **Ignoring cardiovascular symptoms** that outlast a binge, or skipping the history of heart conditions, high blood pressure, psychosis, or bipolar disorder.
- **Treating 3-MMC alone when it is one part of a wider pattern.** This underestimates the timeline.
- **Stopping GHB abruptly** if it is dosed several times daily. That has its own seizure risk.
- **Injection use without bloodborne virus testing and services.**

- **Using alone,** and **isolation.** Redosing decisions happen fastest when you are by yourself.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Because of the mixing risk, keep naloxone and do not use alone.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the cardiovascular danger of cumulative redosing and the added risk of combination toxicity are well-established clinical concerns, and the Kernel itself states that there is no FDA-approved treatment for cathinone use disorder. Evidence specific to 3-MMC is thin, so the Kernel borrows heavily from its methamphetamine and cocaine guides. The supplement stack, the reward-architecture claims, the percentage analogs, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your pattern: typical session length, how often you redose, and the route. The Kernel notes this is what a physician needs to help.
- Every co-used substance, especially opioids, other stimulants, GHB, and alcohol, plus any cardiovascular symptoms during or after binges, even ones that resolved.
- Any personal or family history of heart conditions, high blood pressure, psychosis, or bipolar disorder.
- Whether injection has been part of it, so bloodborne virus testing and injection-site assessment can be arranged, and your DRD2, COMT, MAOA, and MTHFR results.
- A direct question about off-label options such as bupropion and NAC, and, if chemsex was involved, sexual health testing, PrEP, and a chemsex-informed therapist.